IN THE MATTER OF	*	**BEFORE THE**
BRENT FOX, M.D	*	**MARYLAND**
108 Milford Street **Suite 105**	*	**DEPARTMENT**
Salisbury, MD 21804	*	**OF**
Registration No. M26243	*	**HEALTH AND**
	*	**MENTAL HYGIENE**

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NOTICE OF INTENT TO REVOKE CONTROLLED DANGEROUS SUBSTANCE REGISTRATION

In accordance with sections 5-307(d)(4) and 5-308 of the Criminal Law Article, the Department of Health and Mental Hygiene (the "Department") hereby notifies Brent Fox, M.D., 108 Milford Street, Suite 105, Salisbury MD 21804, of the Department's intent to revoke the controlled dangerous substances registration issued to Dr. Fox because he violated Title 5 of the Criminal Law Article. As alleged further below, Dr. Fox failed to comply with the standards of his profession when he prescribed controlled dangerous substances to his patients in violation of section 5-902(c) of the Criminal Law Article.

BASIS FOR ACTION

The following allegations, which the Department believes to be true, support the Department's decision to provide this notice to revoke Dr. Fox's registration to prescribe controlled dangerous substances:

1. On March 13, 2011, the Department issued Dr. Fox, a physician licensed in the State of Maryland to practice medicine, a registration to dispense controlled dangerous substances. The registration expires on March 13, 2013. A copy of the registration is attached as Exhibit 1 to the Order of Summary Suspension of Controlled Dangerous Substances Registration

("Order of Summary Suspension") served simultaneously with this notice and incorporated by reference into this notice.[1]

2. The American Pain Society, the American Academy of Pain Medicine, the Veterans Administration, and the Department of Defense have established clinical practice guidelines for the treatment of patients for pain management. These practice guidelines require a doctor to (1) obtain a comprehensive history; (2) conduct a physical examination and order appropriate diagnostic tests; (3) obtain informed consent from the patient; (4) create an opiod management plan that documents risks and benefits of treatment with opiods; (5) document the patient's response to opiod medication; (6) conduct toxicology screens; (7) refer the patient to appropriate specialists and coordinate care with other health professionals.

3. Likewise, the Maryland Board of Physicians ("BOP") posted on its website a similar standard with which a doctor must comply. At the least, a doctor who manages a patient's pain using controlled dangerous substances must (1) obtain an appropriate medical history, including any history of substance abuse; (2) conduct a physical examination relating to the pain; (3) obtain prior patient records relating to the diagnosis that causes pain and the need for opiate medications; (4) document and reassess the need for opiate medications; (5) refer the patient to appropriate specialists and order diagnostic tests to confirm the diagnosis; (6) conduct toxicology screens; (7) establish a plan for pain management; and (8) consider alternative and adjunctive therapies to opiod treatment.[2]

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[1] Criminal Law Section 5-304 requires an authorized provider to register with the Department before the authorized provider can dispense a controlled dangerous substance. The term "authorized provider" means (i) a person licensed, registered, or otherwise allowed to distribute, dispense, or conduct research on a controlled dangerous substance in the State in the course of professional practice or research. Md. Code Ann., Crim. Law § 5-101(d).

[2] The Federation of the Medical Boards of the United States ("FSMB") also has adopted criteria for evaluating a physician's treatment of pain. These criteria correspond to those announced by the BOP, the American Pain Society, the American Academy of Pain Medicine, the Veterans Administration, and the Department of Defense.

4. MCMC, an independent auditor, conducted a quality review of a sample of Dr. Fox's charts for Johns Hopkins Health. Johns Hopkins Health is part owner of Priority Partners a managed care organization ("MCO") that accepts patients who receive Medicaid from the State of Maryland. Dr. Fox was one of the participating physicians in Priority Partners. MCMC's review disclosed that Dr. Fox failed to conform to the professional standard of care mandated for doctors who practice pain management medicine, and it concluded that Dr Fox

> [i]s in immediate need of review from the DEA and state medical board. His prescribing habits are deplorable and in any state would warrant an immediate suspension order. He fails to employ reasonable safeguards in his practice as evidenced in the charts reviewed. He fails to perform appropriate due diligence as outlined in the FSMB Guidelines in Opiate Prescribing. His prescribing is similar to the pill mills in the southeast and is medically inappropriate, especially the use of two doses of oxycodone in high quantities. His patient population reviewed was a combination of addicts, doctor shoppers, and patients where opiates were unwarranted. His care of the patient and documentation do not support legitimate medial care.

A copy of this letter is attached to the Order of Summary Suspension as Exhibit 2 and incorporated by reference into this notice. As a result of the audit, Priority Partners terminated Dr. Fox.

5. On September 23, 2011, Priority Partners sent a letter to the Department informing the Department that it had terminated Dr. Fox because he failed to comply with professional standards and that his actions placed the public in danger. A copy of the letter is attached to the Order of Summary Suspension as Exhibit 3 and incorporated by reference into this notice.

6. The Department requested the reports and underlying data upon which Priority Partners based its decision. Priority Partners provided the Department with the charts of fourteen of Dr. Fox's patients and a summary of MCMC's findings with respect to each patient.

The charts and summaries are attached to the Order of Summary Suspension as Exhibit 4 and incorporated by reference into this notice. As further described below, Laura Herrera, M.D., the Department's Chief Medical Officer, reviewed these charts independently and also concluded that Dr. Fox's actions failed to comply with professional standards and put his patients and the public in imminent harm. A summary of Dr. Herrera's findings is attached to the Order of Summary Suspension as Exhibit 5 and incorporated by reference into this notice.[3]

7. Finally, the Division of Drug Control ("DDC"), a part of the Department that inspects authorized providers to ensure that they comply with Title 5 of the Criminal Law Article, reviewed Dr. Fox's prescription profiles. DDC also found that Dr. Fox's prescribing practices did not comport with accepted practice and that Dr. Fox placed the public in imminent danger. Specifically, Dr. Fox prescribed cocktails of opiates or very high doses of opiates, contrary to accepted practice. A copy of the DDC report is attached to the Order of Summary Suspension as Exhibit 6 and incorporated by reference into this notice.

SUMMARY OF FINDINGS FOR PATIENT NOS. 1-14

8. With respect to each patient, Dr. Herrera found that the documentation in the chart did not support prescribing any opiates. Overall, Dr. Herrera found the following:

(1) Dr. Fox prescribed excessive quantities of opiates even when the patient failed to describe the alleged pain in any precise manner;

(2) Documentation of findings on physical exams did not support Dr. Fox's prescriptions for opiates;

(3) A patient's physical exam documentation was the same for multiple visits, which suggests that Dr. Fox simply completed an exam template and did not examine the patients;

[3] In order to protect patient privacy, the names of the patients have been removed and have been replaced with a number. The respondent may request a copy of the names that correspond to each number.

(4) All charts were electronically signed on the same day, which also suggests that Dr. Fox simply used a template without examining any patient;

(5) Dr. Fox failed to review records from the patients' other physicians;

(6) Dr. Fox failed to refer patients to other physicians when necessary, or, coordinate his care with other physicians. Significantly, Dr. Fox never consulted with a pregnant woman's obstetrician even though he prescribed high doses of opiates for her.

SPECIFIC FINDINGS

Patient No. 1.

9. **MCMC's Findings. -** MCMC found that Dr. Fox prescribed excessive medication for a non-existent diagnosis. Dr. Fox prescribed 13 pills per day, on average, for six months. Specifically, MCMC found that the patient's chronic pain was ill defined. Dr. Fox accepted the patient's diagnosis of Lyme's disease without conducting any due diligence to confirm the diagnosis. MCMC concluded that Dr. Fox "knew or should have known that the patient was diverting or abusing the medications." MCMC concluded that Dr. Fox put patient No. 1 in clear danger and failed to provide legitimate medical care for her.

10. **Dr. Herrera's Findings. -** Dr. Herrera also found that Dr. Fox did not meet the professional standard of care for this patient. In particular, Dr. Herrera found that Dr. Fox failed to (1) obtain an appropriate medical history from the patient; (2) failed to conduct a comprehensive pain assessment; (3) failed to obtain a history of prior pain treatment; (4) failed to obtain a psychiatric history; (4) failed to conduct a mental status exam; (5) failed to conduct or refer the patient for any diagnostic testing to confirm the alleged diagnosis; (6) prescribed opiates in high dosages (in excess of 200 mg of a morphine equivalent); (7) failed to document or assess

the results of using the opiod medication; (8) failed to refer the patient to appropriate physicians; (9) failed to ensure that the patient contacted and returned to Dr. Fox as recommended in the patient's chart; (10) failed to create any opiod pain management plan.

Patient No. 2.

11. **MCMC's Findings. -** MCMC found Dr. Fox "fell below" the professional standard of care with respect to this patient. Specifically, Dr. Fox failed to confirm the alleged diagnosis of "chronic pain" with any outside records and did not provide any detailed history of the alleged illness. Patient No. 2's urine tested positive for cocaine and tramadol. Nonetheless, Dr. Fox prescribed two short acting opiates in large quantities and failed to assess the harm to the patient of prescribing opiates. MCMC concluded that the sole purpose for documenting anything in the patient's chart was to create a "billable record."

12. **Dr. Herrera's Findings. -** Likewise, Dr. Herrera found that Dr. Fox did not meet the professional standard of care. Specifically, Dr. Herrera found that Dr. Fox (1) failed to obtain an appropriate medical history; (2) failed to assess Patient No. 2's functioning; (3) did not assess Patient No. 2's prior pain treatment; (3) failed to assess the risk of substance abuse; (4) did not obtain or order any diagnostic tests to determine whether there was a legitimate reason for the alleged pain; (5) failed to screen the patient's urine prior to prescribing opiates; (6) prescribed opiates in high dosages (in excess of 200 mg of a morphine equivalent); (7) failed to document or assess the results of using the opiod medication; (8) failed to refer the patient to appropriate physicians; (9) failed to ensure that the patient contacted and returned to Dr. Fox as recommended in the patient's chart; (10) failed to create any opiod pain management plan.

Patient No. 3.

13. **MCMC's Findings. -** MCMC found that Dr. Fox's prescribing of high doses of opiods created a "clear danger" to the public and fell "well outside of lawful prescribing." Significantly, Dr. Fox never documented in the patient's medical history that patient No. 3 was pregnant and his alleged exam notes failed to state that the patient was pregnant. Dr. Fox's notes also were inadequate in other significant areas. They failed to document the need for the large amount of opiods required for the pain reported; they failed to explain why the patient's diagnosis was changed; and they failed to demonstrate why Dr. Fox increased the amount of opiods he prescribed.

14. **Dr. Herrera's Findings. -** Dr. Herrera also found that Dr. Fox failed to meet the professional standard of care. Specifically, Dr. Herrera found that Dr. Fox (1) did not obtain an appropriate medical history; (2) failed to conduct a comprehensive pain assessment; (3) failed to assess the patient's functioning; (4) failed to assess the patient's psychiatric history; (5) failed to obtain or refer the patient for appropriate diagnostic testing to confirm the alleged diagnoses; (6) failed to conduct a urine screen prior to prescribing opiates; (7) prescribed opiates in high doses (excess of the equivalent of 200 mg of morphine); (8) failed to assess the results of using the opiod medication; (9) failed to refer the patient to appropriate physicians; (10) failed to ensure that the patient contacted and returned to Dr. Fox as recommended in the patient's chart; and (11) failed to create any opiod pain management plan.

Patient No. 4.

15. **MCMC's Findings. -** MCMC found that Dr. Fox had no basis for prescribing any opiates to this pregnant woman and that his care was "lacking in all facets." In particular, no particular rationale exists for the alleged pain. Dr. Fox failed to consult with the patient's

psychiatrist even though the patient stated she was diagnosed with bipolar disease. Dr. Fox agreed to add methadone to the already high opiate doses even though it placed the patient and her unborn child at substantial risk. Dr. Fox failed to note any progress in relieving the alleged pain. Dr. Fox failed to obtain records from any other treating physician and failed to perform any due diligence to confirm the alleged pain diagnosis. MCMC concluded that Dr. Fox's notes were created only to allow him to prescribe opiates to the patient and not for any legitimate reason.

16. **Dr. Herrera's Findings. -** Dr. Herrera also found that Dr. Fox failed to comply with the standard of professional care. In particular, Dr. Fox (1) failed to obtain an appropriate medical history; (2) failed to conduct a comprehensive pain assessment; (3) failed to obtain a history of the alleged pain; (4) failed to obtain a history of the alleged injury; (5) failed to obtain a psychiatric history; (6) failed to order any diagnostic test to confirm the alleged pain; (7) failed to conduct any urine screens; (8) prescribed opiates in high dosages (in excess of 200 mg of a morphine equivalent); (9) failed to document or assess the results of using the opiod medication; (10) failed to refer the patient to appropriate physicians; (11) failed to create any opiod pain management plan; and (12) failed to obtain informed consent from the patient for taking opiods.

Patient No. 5.

17. **MCMC's Findings. -** MCMC found that Dr. Fox's prescribing of opiates was outside the standard of care. In particular, MCMC found that Dr. Fox did not obtain records from other provides and did not consult appropriately with other providers. Dr. Fox also failed to obtain a detailed history for the alleged diagnoses and failed to examine the patient appropriately. MCMC also noted that the patient's urine test was positive for opiates, benzodiazepines and tramadol on May 26, 2011. MCMC further noted that even though the

patient's insurance would cover a spinal cord stimulator or spinal cord injections, the patient only wanted opiates and Dr. Fox obliged the patient.

18. **Dr. Herrera's Findings.** - Dr. Herrera also found that Dr. Fox failed to comply with the standard of professional care. In particular, Dr. Fox (1) failed to obtain an appropriate medical history; (2) failed to conduct a comprehensive pain assessment; (3) failed to obtain a history of the alleged pain; (4) failed to assess the patient's ability to function; (5) failed to obtain a proper psychiatric history; (6) failed to order any diagnostic test to confirm the alleged pain; (7) failed to conduct any urine screens; (8) prescribed opiates in high dosages (in excess of 200 mg of a morphine equivalent); (9) failed to document or assess the results of using the opiod medication; (10) failed to refer the patient to appropriate physicians; and (11) failed to create any opiod pain management plan.

Patient No. 6.

19. **MCMC's Findings.** - MCMC found that Dr. Fox prescribed opiates outside the standard of care. Significantly, MCMC found that Dr. Fox increased the patient's opiod dose even though Dr. Fox opined that the patient abused the medication that he prescribed to her, and that she tested positive for both cocaine and Xanax. Additionally, Dr. Fox prescribed pain medication even though no real diagnosis existed. Instead, the patient simply stated she had a sudden onset of pain.

20. **Dr. Herrera's Findings.** - Dr. Herrera also found that Dr. Fox failed to comply with the standard of professional care. In particular, Dr. Herrera found that Dr. Fox (1) did not obtain an appropriate medical history; (2) failed to perform a comprehensive pain assessment; (3) failed to obtain the patient's prior response to pain treatment; (4) failed to assess the patient's functioning; (5) failed to obtain a psychiatric history; (6) failed to assess the risk of substance

abuse; (7) failed to review urine drug screens; (8) prescribed high dosages of opiods (in excess of 200 mg of a morphine equivalent); (9) failed to obtain information about the patient's condition with the opiods; (10) failed to refer the patient to appropriate physicians; (11) failed to ensure that the patient engaged in follow up care that he recommended; and (12) did not create an opiod management plan.

Patient No. 7.

21. **MCMC's Findings.** - MCMC found that Dr. Fox failed to comply with the professional standard of care. In particular, Dr. Fox did not obtain a detailed history of the patient's alleged illness. He did not review any diagnostic tests. Dr. Fox failed to review any urine drug screens, or obtain any records from other physicians. Notably, the patient's urine tested positive for THC, opiates and benzodiazepines.

22. **Dr. Herrera's Findings.** - Dr. Herrera also found that Dr. Fox did not comply with accepted professional standards. In particular, Dr. Herrera fond that Dr. Fox (1) did not obtain an appropriate medical history; (2) did not perform a comprehensive pain assessment; (3) did not obtain the patient's response to pain treatment; (4) did not assess the patient's functioning; (5) did not obtain the patient's prior pain treatment; (6) did not obtain a psychiatric history; (7) did not assess the patient's risk for substance abuse; (8) did not perform, order or review any diagnostic tests; (9) did not obtain or review urine drug screens; (10) prescribed a high dosage of opiates (in excess of 200 mg of a morphine equivalent); (11) did not determine the effect that the opiods he prescribed had on the patient; (12) did not refer the patient to other health professionals when necessary; (13) did not ensure that the patient returned for follow-up care that he recommended; and (14) did not create an opiod treatment plan.

Patient No. 8.

23. **MCMC's Findings.** - MCMC found that Dr. Fox failed to conform to the professional standard of care and that Dr. Fox wrote notes only to bill Medicaid. Dr. Fox's notes for the patients on 12/20/10 and 3/4/11 were identical. MCMC found that Dr. Fox failed to review any of the patient's other medical records and failed to review any diagnostic images. Dr. Fox also prescribed excessive amounts of opiods -- an average of nine pills of oxycodone per day for one year.

24. **Dr. Herrera's Findings.** - Dr. Herrera also found that Dr. Fox failed to conform to the professional standard of care. In particular, Dr. Herrera found that Dr. Fox (1) did not obtain an appropriate medical history; (2) did not perform a comprehensive pain assessment; (3) did not obtain the patient's response to pain treatment; (4) did not assess the patient's functioning; (5) did not obtain the prior pain treatment; (6) did not obtain a psychiatric history; (7) did not obtain a urine screen prior to prescribing opiods; (8) prescribed a high dosage of opiates (in excess of 200 mg of a morphine equivalent); (9) did not determine the effect that the opiods he prescribed had on the patient; (10) did not refer the patient to other health professionals when necessary; (11) did not ensure that the patient returned for follow-up care that he recommended; and(12) did not create an opiod treatment plan.

Patient No. 9.

25. **MCMC's Findings.** - MCMC found that Dr. Fox "prescribed recklessly and without consideration for guidelines or patient safety." MCMC noted that Dr. Fox first reviewed the patient's urine drug screens one and one half years after Dr. Fox began prescribing opiates. The patient's urine drug screens were negative for opiates. Dr. Fox did not obtain any details of

the patient's alleged work injury. Dr. Fox failed to obtain any of the patient's prior medical records.

26. **Dr. Herrera's Findings.** - Dr. Herrera also found that Dr. Fox failed to conform to the professional standard of care. In particular, Dr. Herrera found that Dr. Fox (1) did not obtain an appropriate medical history; (2) did not perform a comprehensive pain assessment; (3) did not obtain the patient's response to pain treatment; (4) did not assess the patient's functioning; (5) did not obtain the patient's prior pain treatment; (6) did not obtain a psychiatric history; (7) did not review or order any diagnostic tests; (8) did not conduct a urine drug screen prior to prescribing opiods; (9) prescribed a high dosage of opiates (in excess of 200 mg of a morphine equivalent); (10) did not determine the effect that the opiods he prescribed had on the patient; (11) did not refer the patient to other health professionals when necessary; and (12) did not create an opiod treatment plan.

Patient No. 10.

27. **MCMC's Findings.** - MCMC found that Dr. Fox failed to comply with the professional standard of care. Dr. Fox prescribed opiates for fibromyalgia syndrome even though the guidelines for treating fibromyalgia do not support such treatment. Dr. Fox also diagnosed the patient with degenerative disk disease even though no support at all existed for such a diagnosis. Instead, the patient's MRI of her spine was normal.

28. **Dr. Herrera's Findings.** - Dr. Herrera also found that Dr. Fox failed to comply with the professional standard of care. In particular, Dr. Herrera found that Dr. Fox (1) did not obtain an appropriate medical history; (2) did not perform a comprehensive pain assessment; (3) did not obtain the patient's response to pain treatment; (4) did not assess the patient's functioning; (5) did not obtain the prior pain treatment; (6) did not obtain a psychiatric history;

(7) did not review or order any diagnostic tests; (8) prescribed a high dosage of opiates; (9) did not determine the effect that the opiods he prescribed had on the patient; (10) did not refer the patient to other health professionals when necessary; and (11) did not create an opiod treatment plan.

Patient No. 11.

29. **MCMC's Findings. -** MCMC found that Dr. Fox failed to comply with the professional standard of care. The patient alleged that her medications were "stolen," and Dr. Fox prescribed a refill. Dr. Fox then prescribed an additional refill only two weeks later even when his progress notes state that the patient's urine tested positive for non-prescribed opiates. Dr. Fox provided no care to the patient. Instead, he only wrote opiod prescriptions for the patient.

30. **Dr. Herrera's Findings. -** Dr. Herrera also found that Dr. Fox failed to conform to the professional standard of care. In particular, Dr. Herrera found that Dr. Fox (1) did not obtain an appropriate medical history; (2) did not perform a comprehensive pain assessment; (3) did not obtain the patient's response to prior pain treatment; (4) did not assess the patient's functioning; (5) did not obtain the patient's prior pain treatment; (6) did not obtain a psychiatric history; (7) did not review or order any diagnostic tests; (8) did not conduct a urine drug screen prior to prescribing opiods; (9) prescribed a high dosage of opiates (in excess of 200 mg of a morphine equivalent); (10) did not determine the effect that the opiods he prescribed had on the patient; (11) did not refer the patient to other health professionals when necessary; and (12) did not create an opiod treatment plan.

Patient No. 12.

31. **MCMC's Findings.** - MCMC found that Dr. Fox failed to comply with the professional standard of care for prescribing opiates. Significantly, Dr. Fox documented that patient No. 12's urines repeatedly tested positive for THC, but nonetheless he prescribed high doses of oxycodone for her. Dr. Fox accepted patient No. 12's statement that she had chronic pain from an accident without obtaining any details about the alleged accident. Dr. Fox stopped treating the patient only when the patient's insurance company informed him that the patient was doctor shopping and that the patient was admitted to a detoxification program.

32. **Dr. Herrera's Findings.** - Likewise, Dr. Herrera found that Dr. Fox failed to comply with the professional standard of care for prescribing opiates. In particular, Dr. Herrera found that Dr. Fox (1) failed to obtain a proper medical history; (2) failed to perform a comprehensive pain assessment; (3) failed to assess the patient's functioning; (4) failed to obtain a history of her prior pain treatment; (5) failed to obtain a psychiatric history; (6) failed to obtain or order any diagnostic testing for the alleged injury; (7) failed to obtain a urine drug screen prior to prescribing opiates; (8) prescribed a high dose of opiods (in excess of 200 mg of a morphine equivalent); (9) failed to document or assess the results of using the opiod medication; (10) failed to refer the patient to appropriate physicians; and (11) failed to create any opiod pain management plan.

Patient No. 13.

33. **MCMC's Findings.** - MCMC found that Dr. Fox failed to comply with the professional standard of care. Dr. Fox only provided the patient medication and did not provide any other type of care for her, even though he noted that the patient abused heroin. The patient's

urine tested positive for benzodiazepines and for Suboxone. Dr. Fox failed to order any diagnostic imaging for the alleged pain.

34. **Dr. Herrera's Findings.** - Likewise, Dr. Herrera found that Dr. Fox failed to comply with the professional standard of care for prescribing opiates. In particular, Dr. Herrera found that Dr. Fox (1) failed to obtain a proper medical history; (2) failed to perform a comprehensive pain assessment; (3) failed to obtain the patient's prior response to pain treatment; (4) failed to assess the patient's functioning; (5) failed to obtain a history of her prior pain treatment; (6) failed to obtain a history of the alleged injury; (7) failed to obtain a psychiatric history; (8) failed to obtain or order any diagnostic testing for the alleged injury; (9) failed to obtain a urine drug screen prior to prescribing opiates; (10) prescribed a high dose of opiods (in excess of 200 mg of a morphine equivalent); (11) failed to document or assess the results of using the opiod medication; (12) failed to refer the patient to appropriate physicians; and (13) failed to create any opiod pain management plan.

Patient No. 14.

35. **MCMC's Findings.** - MCMC found that Dr. Fox failed to conform to the professional standard of care. Dr. Fox only prescribed pain medication for this patient and did not order any other types of therapies. The patient reported to Dr. Fox that she had been hospitalized for depression and anxiety five or six times in the past, but Dr. Fox failed to address her psychiatric illness.

36. **Dr. Herrera's Findings.** - Likewise, Dr. Herrera found that Dr. Fox failed to comply with the professional standard of care for prescribing opiates. In particular, Dr. Herrera found that Dr. Fox (1) failed to obtain a proper medical history; (2) failed to perform a comprehensive pain assessment; (3) failed to assess the patient's functioning; (4) failed to obtain

a history of her prior pain treatment; (5) failed to obtain a history of the alleged injury; (6) failed to obtain a psychiatric history; (7) failed to obtain a urine drug screen prior to prescribing opiates; (8) prescribed a high dose of opiods (in excess of 200 mg of a morphine equivalent); (9) failed to document or assess the results of using the opiod medication; (10) failed to refer the patient to appropriate physicians; and (11) failed to create any opiod pain management plan.

NOTICE OF POSSIBLE SANCTIONS

Dr. Fox's failure to comply with the professional standard of care in prescribing controlled dangerous substances requires revocation of his controlled dangerous substance registration.

ORDER TO SHOW CAUSE

A Show Cause Hearing will be held on January 17, 2012, beginning at 9 A.M., before an Administrative Law Judge at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031.

PROCEDURES FOR SHOW CAUSE HEARING

The Show Cause Hearing is a contested case hearing and will proceed under the Maryland Administrative Procedures Act, Md. Code Ann., State Gov't § 10-201 et seq.

At the Show Cause Hearing, an attorney may represent Dr. Fox. Dr. Fox or his attorney may call witnesses, offer evidence, including rebuttal evidence, cross-examine any witnesses, present summation, and argument and subpoena witnesses with appropriate costs assessed to Dr. Fox.

If Dr. Fox fails to attend the Show Cause Hearing or if Dr. Fox fails to attend the Show Cause Hearing, then the Department may revoke Dr. Fox's controlled dangerous substance registration.

Dr. Fox, or his counsel, may address questions to the administrative prosecutor, Lisa A. Barkan, Administrative Prosecutor, Assistant Attorney General, Office of the Attorney General, Secretary of Health and Mental Hygiene, Ste. 302, 300 W. Preston St., Baltimore, Maryland, 21201, 410-767-1877, lbarkan@dhmh.state.md.us.

12/6/11
Date

Joshua M. Sharfstein, M.D.
Secretary